



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTUS SANTA ROSA PHYSICIANS
AMBULATORY SURGERY CENTER
7902 EWING HALSELL
SAN ANTONIO TX 78229

Respondent Name

FIRST LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-2497-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been appealed with the carrier with no resolution. The code of 23120 should have paid 1313.58 at 50% of the MARS according to DWC ASC Guidelines and code 23130 has the 59 modifier attached for distinct separate procedure and should have received reimbursement."

Amount in Dispute: \$1321.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The primary procedure performed was CPT 23412...CPT 23130...was billed with Modifier 59 indicating that this was a separate and distinct procedure since according to the Medicare Correct Coding Guidelines, this was considered a standard of medical surgical practice but payable with a modifier." "Use of Modifier 59 when billing a combination of codes that would normally not be billed together. This modifier indicates that the ordinarily bundled code represents a service done at a different anatomic site or at a different session on the same date." "The operative report shows no separate incision made in the performance of CPT 23130; therefore, the Modifier 59 was incorrectly applied and according to the Medicare Correct Coding guidelines, payment for this combination of codes is allowed with the **correct** assignment of Modifier 59."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2010	ASC Services for Code 23130-SG-59	\$1321.06	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 8, 2010

- 97-Payment is included in the allowance for another service/procedure.
- U756-Repair of complete shoulder rotator cuff includes acromioplasty.

Explanation of benefits dated June 18, 2009

- 45-Charges exceed your contracted/legislated fee arrangement.
- 770-Complex bill review.

Issues

1. Did the requestor support position that additional reimbursement is due for ASC services for code 23130-SG-59? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

On October 13, 2010, the Division submitted a notice requesting a copy of the contract between the network and the health care provider in this dispute. The insurance carrier's representative acknowledged receipt of the notice on October 14, 2010. The notice provided for a deadline to submit the requested information no later than fourteen (14) days after receipt of the notice. The insurance carrier failed to provide a copy of the requested documentation. For that reason, the services in dispute will be reviewed in accordance with 28 Texas Administrative Code §134.402.

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

HCPCS code 23130 is defined as "Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release."

Per National Correct Coding Initiatives, HCPCS code 23412 and 23130 are comprehensive codes and are typically not billed separately; however a modifier is allowed to designate a different service.

The requestor added modifier "59" to HCPCS code 23130.

Modifier 59 - Distinct Procedural Service is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the operative report indicates that the claimant underwent the following procedures: 1) Repair of

right rotator cuff with a 5.5 suture anchor; 2) Repair of right subscapularis for biceps stabilization; 3) Neer acromioplasty, right; 4) Mumford distal clavicle resection, right; and 5) Labral debridement, right.”

The Division finds that the requestor did not support the use of modifier “-59” as a distinct procedural service. The requestor did not support that HCPCS code 23130 is not global to 23412. Therefore, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	2/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.